Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: CARL M. NAEHRITZ, III, D.C. 2900 HIGHWAY 121, SUITE 120 BEDFORD, TX 76021	MFDR Tracking #: M4-09-7016-01 DWC Claim #: Injured Employee:
Respondent Name and Box #: AMERICAN HOME ASSURANCE CO Box #: 19	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After many unsuccessful attempts to resolve the issues of medical payments with Hartford/Corvel Insurance Company. {sic} I am submitting the enclosed file along with the entire Original HCFA's, Resubmitting HCFA's with all EOB's and supporting documentation attached. _____injured his lower back on 11/26/2003, when he was lifting luggage onto the airplane. _____'s symptoms are described as sharp, throbbing, aching, stiffness and swelling. _____did not have these symptoms before the accident. _____had a flare up on 08/26/2008 when he reaggravated his lower back area. On August 28, 2008, we received a referral from his primary doctor (Sharon Gibbs, M.D.). On 09/03/2008, _____saw Dr. Naehritz for his Initial Evaluation. On 09/03/2008, dr. Naehritz submitted a request for treatment, there was no answer to the request, and on 09/25/2008 reconsideration was done and faxed. On 09/30/2008, Dr. Naehritz was given approval for 6 sessions starting on 09/26/2008 to 10/29/2008 using authorization number 71187831. Texas codes that were approved were 97140, 97530, G0283, 97110, and 97035. Hartford/Corvel Insurance Company continued to deny payments for services 09/03/2008 through 11/03/2008, when we had already received approval to treat the patient from Corvel authorization department. These dates of service were denied, based on the reasons that I have listed below: 1. Denied services not prescribed prior to delivery: This excuse was used to deny payment for the patient initial visit with the doctor. In order for the treating doctor to submit a request for approval to treat we have to do an initial evaluation on the patient first, so Hartford/Corvel should have paid this date of service in full. 2. Payment adjusted for absence of pre-cert/pre-auth.: There was no reason for this denial because we had approval to treat the patient. We had followed all rules and regulations and Hartford/Corvel did not pay the claims. Hartford/Corvel should pay in full the claims because we had the pre-approval already pre-cert. #71187831. 3. Denied, provider not eligible to perform service. This excuse was used once again to deny payment; of course the doctor is eligible to perform services with the patient. Doctor has been practicing chiropractic for 20 years now. Hartford/Corvel should be penalized for using this denial on approved treatment, and they should pay in full. We are on Corvel Corcare list of treating doctors. 4. Service not deemed Medically Necessary by payer. This excuse was used to deny payment on a supply (E0190-cervical pillow). Supplies do not need to be authorized, treatment was authorized and the doctor felt that this cervical pillow would help the patient with his back pain, so it was part of the approved treatment. Hartford/Corvel should pay in full. 5. Non-covered procedure per state regulation. Again this excuse was used to deny payment for the supply. Doctor felt it was medically necessary to issue the patient the cervical pillow as part of his treatment. Hartford/Corvel should pay for the unreasonable delay in payments. Cervical Pillow was prescribed to help on _____'s back pain. I respectfully request the board to find that all services and supplies were needed and were medically necessary. Also penalty, and interest payment is due for this unreasonable delay in the payment of this claim, with 50% of the total bill to be paid immediately, as set up in the TDI (Texas Department of Insurance) Regulations 133.304(d)."

Amount in Dispute: $122.61*

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The above requestor has filed with Medical Dispute Resolution for dates of service 09/03/2008, 10/3/2008,10/24/2008,11/3/2008 and 11/10/2008, for a total amount of $1253.95. The requestor has stated in their dispute "Patient initial visit. As above authorization was given to treat the patient. Auth #71187831. Authorization was given to treat the Patient auth. #: 71187831. Regarding date of service 9/3/2008. The requestors argument that this is

the initial visit may hold true to their treatment of the claimant but the claimant's DOI is 11/26/2003 and the claimant had treated with other providers prior to seeing Dr. Carl Naehritz III. This visit for physical therapy would have required preauthorization under TDI-DWC rule 134.600. No additional payment should be recommended. Regarding dates of service 10/3/2008 and 10/24/2008. I can verify that the preauthorization number supplied did cover this date of service. We were informed by the adjuster not to allow payment for the reason, "Do not pay, not an authorized provider." Regarding dates of service 11/3/2008 and 11/10/2008. The preauthorization number supplied, 71187831-1, was effective from 9/29/2008 through 10/29/2008. Therefore this treatment fell outside of the preauthorization phase and an extension of the authorization should have been requested. No additional payment should be recommended."

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
10/24/08	97530	N/A	$62.61	$0.00
11/3/08	99213-25	N/A	$60.00	$0.00
			Total Due:	$0.00

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

*The division received an updated DWC-60 table of disputed services from the requestor on 11/15/2010 with $122.61 as the remaining total amount in dispute for dates of service 10/24/2008 and 11/3/2008.

Background

1. 28 Tex. Admin. Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.203 sets out the medical fee guidelines for professional services rendered on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 12/20/2008 for dates of service 10/24/2008 and 11/3/2008
   - 174 – Denied; service not prescribed prior to delivery
   - 185 – Denied; provider not eligible to perform service
   - W1 – Workers' compensation state fee schedule adj

   Explanation of benefits dated 2/23/2009 for date of service 10/24/2008
   - 174 – Denied; service not prescribed prior to delivery
   - 185 – Denied; provider not eligible to perform service
   - W4 – No additional payment allowed after review

   Explanation of benefits dated 4/10/2009 for date of service 10/24/2008 submitted by the respondent
   - B15 – Procedure/Service is not paid separately
   - R88 – CCI; Mutually exclusive procedure
   - W4 – No additional payment allowed after review

Issues

1. Is CPT code 97530-GP included in the pre-authorization request and is the code bundled into any other services the requestor billed on the same day per the NCCI edits?
2. Does the submitted documentation support the services billed under CPT code 99213?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed CPT code 97530-GP for date of service 10/24/08. The insurance carrier denied this code on the EOB's dated 12/20/2008 and 2/23/2009 with reason codes "174" - Denied; service not prescribed prior to delivery and "185" - Denied; provider not eligible to perform service. The Respondent submitted a third EOB dated 4/10/2009 denying the code with reason codes "B15" - Procedure/Service is not paid separately and "R88" - CCI; Mutually exclusive procedure. The requestor submitted a copy of a preauthorization determination supporting that CPT code 97035 is approved with a start date of 9/29/08 and end date of 10/29/08. The insurance carrier's denial of "174" is not supported. The insurance carrier did not submit any documentation supporting the denial of reason code "185". Therefore, the insurance carrier of this denial is not supported. According to the NCCI edits, CPT code 97530-GP is bundled into another service the requestor billed on the same day. Pursuant to rule §134.203(b)(1) For coding, billing,

reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: Medicare payment policies, including its coding; billing; **correct coding initiatives (CCI) edits**; modifiers; and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules. Therefore, reimbursement to the requestor for CPT code 97530-GP is not recommended.

2. The requestor billed CPT code 99213 (established patient office or other outpatient visit) and appended modifier-25 (significant, separately identifiable evaluation and management service by the same physician on the same day of the procedure or service) for date of service 11/3/08. There are no medical records submitted in this dispute to support the billing of CPT code 99213-25. Pursuant to rule §133.307(c)(2)(E) Provider requests for medical dispute resolution (MDR) shall be filed in the form and manner prescribed by the Division. The request shall include: a copy of all applicable medical records specific to the dates of service in dispute. Therefore, reimbursement to the requestor for CPT code 92213-25 is not recommended.

Conclusion

For the reasons stated above, the division finds that the requestor has failed to establish that reimbursement is due. As a result, the amount ordered is $0.00.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature	Medical Fee Dispute Resolution Officer	**4/14/11** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.